INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Obstetrical and Gynecological Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: September 27, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: February 23, 2017	*Core*MMIS update	FSSA and HPE
2.0	Policies and procedures as of May 1, 2017 Published: August 1, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of July 1, 2018 Published: January 10, 2019	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of February 1, 2020 Published: March 26, 2020	Scheduled update	FSSA and DXC
5.0	Policies and procedures as of October 1, 2020 Published: December 22, 2020	Scheduled update: • Edited text as needed for clarity • Added reference to the *Genetic Testing* module in the *Gynecological Services* section • In the *Provider Restrictions for High-Risk Pregnancy Care* section, replaced billing information with a reference to the *Medical Practitioner Reimbursement* module • Updated the *Prenatal Ultrasounds (Sonography/Echography)* section	FSSA and Gainwell

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Obstetrical and Gynecological Services

*Note: With the exception of the Notification of Pregnancy section, the information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide available at in.gov/medicaid/providers.*

For updates to information in this module, see IHCP Banner Pages and Bulletins at in.gov/medicaid/providers.

Introduction

This module presents Indiana Health Coverage Programs (IHCP) coverage, billing, and reimbursement policies for gynecological and obstetrical services, including prenatal care, delivery, and postpartum care.

Gynecological Services

The IHCP covers gynecological services, including cervical cancer screenings, pelvic exams, and medically necessary hysterectomies, as described in the following sections. For information about contraception and sterilization, see the *Family Planning Services* module. For information on genetic testing, including for breast, ovarian, and related cancers, see the *Genetic Testing* module.

Cervical Cancer Screenings

The IHCP covers cervical cancer screening services, including cytology Pap smear and human papillomavirus (HPV) testing, as well as medically necessary services such as the collection of the samples, screening by a cytotechnologist, and a physician's interpretation of the test results.

The IHCP follows the current recommendations for cervical cancer screening set by the U.S. Preventive Services Task Force (USPSTF) and the American Society for Colposcopy and Cervical Pathology (ASCCP). For repeat testing, cytological thresholds for further diagnostic testing (colposcopy) and treatments, and extended surveillance, the IHCP follows the recommendations of the ASCCP.

Detailed information regarding these recommendations can be found on the USPSTF website at uspreventativeservicestaskforce.org and the ASCCP website at asccp.org.

Pelvic Examination

The IHCP covers pelvic examinations (including breast examination) for female members.

A pelvic exam performed under anesthesia may be done as part of another gynecological surgical procedure or as a single procedure. The IHCP covers anesthesia/conscious sedation, when required for a member, to enable the practitioner to complete the exam. Based on accompanying documentation, medically necessary care provided prior to surgery will be reimbursed.

Hysterectomy

The IHCP covers medically necessary hysterectomies performed to treat an illness or injury. The IHCP does **not** cover hysterectomies performed solely to render a member permanently incapable of bearing children, whether performed as a primary or secondary procedure. For information about **sterilization** services, see the *Family Planning Services* module.

Hysterectomy procedures must comply with *Code of Federal Regulations 42 CFR 441.250-441.259* and with *Indiana Administrative Code 405 IAC 5-28-9*. Hysterectomy is subject to prior authorization. In accordance with *42 CFR 441.255*, the IHCP pays for hysterectomies performed during an individual's retroactive eligibility if documentation requirements are met.

Informed Consent and Acknowledgement Statement for Hysterectomies

The IHCP covers hysterectomy **only** when medically necessary and (except as described later in this section) **only** when the member has given informed consent. The provider must have informed the member both orally and in writing that the procedure will render the member permanently incapable of reproducing, and the member or member's representative must have signed a written acknowledgement of receipt of that information. See Figure 1 for a sample acknowledgement form. **Providers cannot, under any circumstances, use the *Consent for Sterilization* form for hysterectomy procedures.**

The signed acknowledgement of receipt of hysterectomy information is required in all cases, except when the patient is already sterile or a life-threatening emergency exists for which the physician determines prior acknowledgement is not possible. The physician who performs the hysterectomy under these circumstances must complete one of the following certification requirements:

- Certify in writing that the individual was **already sterile** at the time the hysterectomy was performed. The certification must state the cause of the sterility at the time of the hysterectomy.
- Certify in writing that the hysterectomy was performed under a **life-threatening emergency** in which the physician determined that prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency.

Figure 1 – Example of *Acknowledgement of Receipt of Hysterectomy Information*

Acknowledgement of Receipt of Hysterectomy Information

Member Name: _____

IHCP Member ID: _____

Physician Name: _____

NPI or IHCP Provider ID: _____

AMA Education Number: _____

It has been explained orally and in writing to _____ that the hysterectomy to be performed on her will render her permanently incapable of bearing children.

☐ Signed before surgery

☐ Signed after surgery (at the time of the hysterectomy, eligibility was not established).

_____ _____

(Member or Representative Signature) (Date)

Physician Statement

The hysterectomy in the above case is being done for medically necessary reason(s), and the resulting sterilization is incidental and is not, at any time ever, the reason for this surgical operation.

Diagnosis(ses)

_____

_____ _____

(Physician Signature) (Date)

Claims billed with Current Procedural Terminology (CPT®[1]) or ICD-10 procedure codes for hysterectomy services require documentation necessary to satisfy requirements for informed consent or physician certification of preexisting sterility or life-threatening emergency. For applicable codes, see the *CPT Procedure Codes for Hysterectomy* and *ICD-10 Procedure Codes for Hysterectomy* tables in *Obstetrical and Gynecological Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Providers must attach the appropriate documentation to the paper claim form, upload it to the IHCP Provider Healthcare Portal (Portal) claim, or send it separately as an attachment to the electronic claim transaction (as described in the *Paper Attachments with Electronic Claims* section of the *Claim Submission and Processing* module). Providers of all hysterectomy-related services must attach a copy of the appropriate acknowledgement or physician certification to the claim. This requirement extends to **all** providers, including attending physicians and surgeons, assistant surgeons, anesthesiologists, inpatient and outpatient hospital facilities, and other providers of related services. The primary service provider should forward copies of the acknowledgement or physician certification statement to the related service providers to ensure timely payment.

[1] *CPT copyright 2020 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Prior Authorization for Total or Supracervical Hysterectomy

Prior authorization for total or supracervical (partial) hysterectomies will be granted for members with documentation supporting one of the following:

- Nonmalignant uterine tumor causing one of the following:
  - Enlarged uterus, with ill-defined adnexa
  - Postmenopausal enlargement with or without symptoms
  - Rapid uterine growth over the last 6 months
  - Pressure on adjacent organs
  - Abnormal bleeding (lasting longer than 8 days for more than two cycles, requiring additional bleeding protection, defined as large clots and gushes, limiting activity)
- Cervical intraepithelial neoplasia (CIN) III, diagnosed by cervical biopsy and/or endocervical curettage and confirmed by excisional biopsy (to exclude invasive disease), including cold knife conization, loop electrosurgical excision procedure (LEEP), large loop excision of transformation zone (LLETZ), or loop surgical excision
- Fibroids in premenopausal member with uterus greater than 12 weeks' gestational size or documentation of need for abdominal rather than vaginal approach; and one of the following:
  - Abnormal bleeding
  - Uterus size doubled within 1 year
  - Ureteral compression diagnosed by appropriate imaging modalities (for example, ultrasound, intravenous pyelogram [IVP], computerized tomography [CT] scan)
  - Other symptoms, such as urinary frequency or urgency, dyspareunia, or pelvic or abdominal pain or discomfort without other explanation
- Fibroids in postmenopausal member with uterus greater than 12 weeks' gestational size or documentation of need for abdominal rather than vaginal approach; and one of the following:
  - Uterus size doubled within any time period
  - Ureteral compression by appropriate imaging modalities (for example, ultrasound, IVP, CT scan)
  - Other symptoms, such as urinary frequency or urgency, dyspareunia, or pelvic or abdominal pain or discomfort without other explanation
  - Normal Pap or HPV testing within 3 years
- Dysfunctional uterine bleeding in premenopausal member with all of the following:
  - Abnormal bleeding uncontrolled by conservative therapy, such as hormonal therapy
  - No evidence of cancer demonstrated by hysteroscopy, endometrial biopsy, or dilation and curettage (D&C)
  - No detectable structural or anatomic cause for the bleeding
  - Normal Pap or HPV testing within 3 years
- Postmenopausal bleeding (defined as bleeding more than 1 year after last menstrual period) with all of the following:
  - Abnormal bleeding continued after change in or discontinuation of hormone replacement therapy, if previously used
  - No evidence of cancer demonstrated by hysteroscopy, endometrial biopsy, or D&C
  - No detectable structural or anatomic cause for the bleeding
  - Normal Pap or HPV testing within 3 years
- Pelvic inflammatory disease (PID) with one of the following:
  - Suspected rupture or leakage of pelvic abscess
  - Unsuccessful management with antibiotics for 10 to 14 days
  - Surgery for residual, inactive but symptomatic disease, if conservative therapy is not possible

- Chronic PID with both of the following:
  - Chronic pelvic pain
  - Adhesions, scarring, or hydrosalpinx
- Recurrent abnormal uterine bleeding (lasting longer than 8 days for more than two cycles, requiring additional protection, defined as large clots and gushes, with limitations of normal activity) and benign endometrial biopsy after failed medication therapy – excluding members on birth control pills or those with intrauterine devices (IUDs).
- Chronic incapacitating pelvic pain that is unresponsive to conservative therapy, such as analgesics, and evidence of normal gastrointestinal (GI)/genitourinary (GU) evaluations, as exhibited by the following:
  - A 4- to-6-month failed trial of oral contraceptives, diuretics, anti-inflammatories, or induced amenorrhea
  - Negative examinations of urinary tract (UT), GI tract, and musculoskeletal system
  - No etiology of pain revealed in psychological counseling
- Benign or malignant ovarian tumor and/or cyst in postmenopausal (more than 1 year) member
- Uncontrolled postpartum bleeding within 6 weeks of delivery, uncontrolled by drug therapy (for example, Pitocin, Methergine, or prostaglandin therapy) or D&C
- A diagnosis of placenta accreta, increta, or percreta
- Endometriosis uncontrolled by hormonal therapy (for example, depot medroxyprogesterone, oral contraceptives, gonadotropin-releasing hormone [GnRH] agonist, or danazol), surgical ablation, or excision
- Tubo-ovarian abscess
- Urinary or fecal incontinence due to fistula into vagina, uterus, perineum, or rectum; and fistula demonstrated by cystoscopy, proctoscopy, radiological examination, visual inspection, or probing
- Uterine prolapse, stage or grade 2 or higher, and one of the following:
  - Pain
  - Pelvic pressure
  - Stress incontinence
  - Ulceration of vaginal mucosa or cervix with bleeding or spotting
  - Vaginal splinting

Notification of Pregnancy

Early prenatal care can address potential health risks that contribute to poor birth outcomes. In addition, earlier enrollment of pregnant women in Medicaid case management programs is associated with better birth outcomes. The Family and Social Services Administration (FSSA) data shows that some low-income pregnant women do not seek prenatal services in the earliest stages of pregnancy, which often leads to untreated health risks. The FSSA Neonatal Quality Committee, made up of Indiana health professionals, has identified early prenatal care and the identification of health-risk factors of expectant mothers as an area of focus.

Within managed care programs, the FSSA uses the Notification of Pregnancy (NOP) form to improve the identification of health-risk factors of expectant mothers as early as the first trimester of pregnancy. NOPs can be completed at any time during the managed care member's pregnancy, preferably during the initial visit, to document and monitor pregnancy conditions. If a managed care member's normal pregnancy becomes high-risk (see the *High-Risk Pregnancy* section), providers should use the NOP to document the change.

Providers may receive $60 for one NOP per managed care member, per pregnancy. The following requirements must be met for a provider to be eligible for reimbursement for submitting an NOP:

- The NOP must be submitted via the Portal no more than 5 calendar days from the date of the office visit on which the NOP is based.
- The member's pregnancy must be less than 30 weeks gestation at the time of the office visit on which the NOP is based.
- The member must be enrolled with a managed care entity (MCE), including pregnant women enrolled in an MCE through Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise, as well as presumptively eligible pregnant women enrolled with an MCE.
- The NOP cannot be a duplicate of a previously submitted NOP.

> *Note: Duplicate NOPs (those for the same woman and the same pregnancy) do not qualify for the $60 reimbursement. Only one NOP per member, per pregnancy is eligible for reimbursement. Recognized providers receive a systematic message if the NOP appears to be a duplicate.*

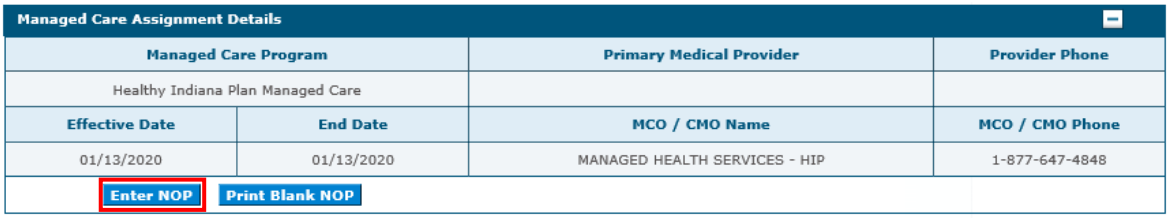
For more information on NOP, see the *Notification of Pregnancy* page at in.gov/medicaid/providers.

Submitting a Notification of Pregnancy

Recognized providers complete and submit the NOP electronically using the Portal. After logging in, complete the following steps:

1. Select the **Eligibility** tab to verify the member's eligibility.
2. In the *Eligibility Verification Request* panel, enter any of the following three search criteria for the member:
   - Member ID
   - Social Security number (SSN) and birth date
   - Last name, first name, and birth date
3. Enter a date or date range for the inquiry. If no date is entered in the Effective From field, the system defaults to the current date.
4. Click **Submit**.
5. In the Coverage column of the *Eligibility Verification Information* panel, click the link for the member's managed care plan to access the *Coverage Details* page.
6. Click [+] to expand the *Managed Care Assignment Details* panel (Figure 2) and then click **Enter NOP** to begin the process of completing the NOP online. (The option to print a blank NOP is also available; however, note that only NOPs submitted online are reimbursable.)

Figure 2 – Enter NOP Option on the Managed Care Assignment Details Panel



7. Complete all information on the NOP form. An asterisk (*) indicates a required field.
8. Click **Submit** to submit the NOP.
9. The Portal checks for potential duplicate NOPs. If a duplicate is identified, the recognized provider is asked to provide a reason why the new NOP is not a duplicate. The recognized provider can choose from three reasons related to the prior pregnancy:
   - Member abortion
   - Member preterm delivery
   - Member miscarriage

   The provider can continue the process without identifying a reason; however, the duplicate NOP will not be reimbursed.
10. After submitting the NOP, click **Print NOP** to print the completed NOP for documentation purposes, or click **Close** to close the window without printing.

> *Note: Submit the NOP within 5 calendar days from the date of the office visit. NOPs submitted more than 5 days from the date of the office visit are not reimbursed.*

Search for NOPs

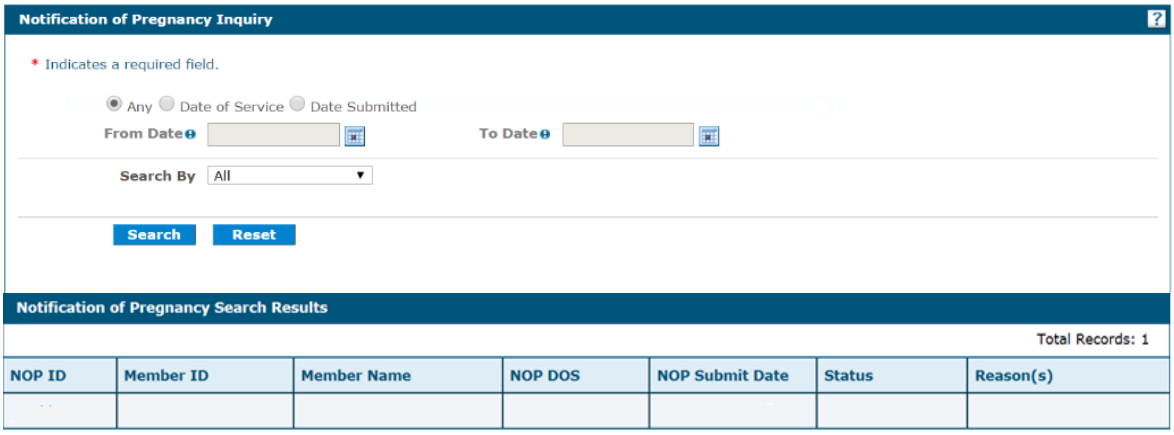
To search the Portal for NOPs that were previously submitted on a member's behalf, log in to the Portal and complete the following steps:

1. Select **Notification of Pregnancy Inquiry** from the Care Management tab on the menu bar.
2. In the *Notification of Pregnancy Inquiry* panel (Figure 3), search for all dates or select a date range, either for date of service or for the date the NOP was submitted.

> *Note: The Search By drop-down menu allows users to search all NOPs or search by Member ID, Member SSN, Member Name, or NOP ID.*

3. Click **Search** to view results that meet the criteria selected.

Figure 3 – NOP Inquiry on the Portal



Billing for Submitted Notifications of Pregnancy

For NOP claims, bill using CPT code 99354 with modifier TH:

- 99354 – Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service, first hour (list separately)
- TH – Obstetrical treatment/services, prenatal or postpartum

The date of service on the NOP claim should be the date the provider completed the risk assessment during a visit with the pregnant woman.

NOP claims should be submitted to the appropriate managed care entity. Physicians can submit claims for NOP reimbursement using the *CMS-1500* claim form or the 837P electronic transaction. Hospitals can submit claims for NOP reimbursement using the *UB-04* claim form or the 837I electronic transaction. NOP claims from hospitals must be coded with revenue code 960 – *Professional fees– General*, in addition to CPT code 99354 with modifier TH.

Billing for Pregnancy-Related Services

Providers must indicate pregnancy and enter the date of last menstrual period (LMP) on all professional claims for pregnancy-related services. Providers must indicate pregnancy and include the LMP date as follows, depending on claim submission method:

- *CMS-1500* claim form – Enter the LMP date in field 14. Enter the pregnancy indicator **P** in field 24H for each service detail.
- Portal professional claim (FFS billing only) – During Step 1 of the claim submission process, in the *Claim Information* section, select **Pregnancy** as the Date Type and enter the LMP date in the Date of Current field.
- 837P electronic transaction – Indicate pregnancy by submitting **Y** in PAT09 in the 2000 loop. Submit LMP information in the DTP segment in the 2300 loop with a qualifier of 484.

When billing for pregnancy-related services on the professional claim, providers must indicate a pregnancy-related diagnosis code as the primary diagnosis (the first diagnosis code entered on the claim) and for each service detail, using diagnosis pointers. For a list of diagnosis codes for normal, low-risk pregnancy and for high-risk pregnancy, see *Obstetrical and Gynecological Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Providers must enter the charged amount for each prenatal visit and for each postpartum visit. The charged amount is entered in field 24F ($ Charges) on the *CMS-1500* claim form, the Charged Amount field in the Portal professional claim, or the Line Item Charge Amount field on the 837P electronic transaction.

Federal regulations allow providers to bill claims for certain prenatal services to the IHCP first, even if the member has insurance coverage through another carrier. For a list of relevant diagnosis codes, see *Prenatal and Preventive Pediatric Care Diagnosis Codes That Bypass Cost Avoidance*, accessible from the *Code Sets* page at in.gov/medicaid/providers. For more information, see the *Third-Party Liability* module.

The IHCP limits payment for pregnancy-related services subject to prior authorization restrictions and in accordance with *Indiana Administrative Code (IAC)*.

Note:	*The IHCP does not require a copayment for drugs dispensed to a pregnant member. No copayment is required for transportation provided to pregnant members; however, transportation exceeding the 50-mile one-way trip limitation is subject to prior authorization. See the Transportation Services module for additional information.*

Prenatal Care

The IHCP covers prenatal care delivered according to national standards as outlined by the American College of Obstetricians and Gynecologists (ACOG), American Academy of Pediatrics (AAP), and the Agency for Healthcare Research and Quality (AHRQ).

Prenatal Visits

The IHCP reimburses up to 14 visits for prenatal care during a normal pregnancy, as follows:

- Three visits in the first trimester
- Three visits in the second trimester
- Eight visits in the third trimester

> *Note: A normal pregnancy is defined as one in which the physician determines the pregnant woman is not at risk of a preterm birth or poor pregnancy outcome due to medical or psychosocial reasons. Additional prenatal care visits are allowed for members considered to have a high-risk pregnancy; see the High-Risk Pregnancy section.*

To identify prenatal visits in each trimester, providers must bill the procedure code for the visit in conjunction with the appropriate U1, U2, or U3 modifier for each specific date of service:

- U1 – Trimester one – 0 through 14 weeks, 0 days
- U2 – Trimester two – 14 weeks, 1 day through 28 weeks, 0 days
- U3 – Trimester three – 28 weeks, 1 day through delivery

For the first prenatal visit, an evaluation and management (E/M) procedure code may be used to accommodate the greater amount of work involved. For subsequent visits, prenatal-care-only codes should be used. For additional details, see the *Prenatal Visit Procedure Codes and Billing Instructions* table in *Obstetrical and Gynecological Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

> *Note: Prenatal-care-only CPT procedure codes 59425 and 59426 billed with modifiers U1, U2, or U3 are not subject to National Correct Coding Initiative (NCCI) Column I/II editing when billed on the same date of service as applicable laboratory procedure codes.*

Providers should list each prenatal visit individually on the professional claim (*CMS-1500* claim form or electronic equivalent) and submit claims after each individual visit or at the end of the respective trimester. Prenatal visits in the same trimester should be billed within 30 days of the end of the trimester. Providers should bill prenatal care for pregnant members separately from the delivery and postpartum visits, using the appropriate procedure codes for each service.

See the *Billing for Pregnancy-Related Services* section for general billing information applicable to all pregnancy-related services.

Office Visits during Pregnancy for Concurrent Medical Condition

With the exception of the first prenatal visit (which providers can bill using an appropriate E/M code and applicable trimester modifier, as indicated in the *Prenatal Visits* section), E/M procedure codes should not be used for office visits related to prenatal care. However, providers can bill E/M procedure codes 99211–99215 for office visits rendered to pregnant members if the service is related to a *concurrent* medical condition requiring medical care or consultative referral. Providers must identify the concurrent condition as a primary or secondary condition by a valid ICD diagnosis code and indicate the appropriate

diagnosis code in the diagnosis pointer field for the service billed. Additionally, providers can bill the first prenatal visit with E/M codes 99201–99215, the appropriate trimester modifier, and the expected date of delivery all indicated on the claim.

Prenatal Tests and Screenings

In addition to the prenatal visits, the IHCP covers prenatal tests and screenings delivered according to standards established by the ACOG and the AAP.

Providers can bill prenatal tests and screenings along with the appropriate visit code on the same *CMS-1500* claim form, Portal professional claim, or 837P electronic transaction.

> *Note: Providers are not allowed to bill separately for each component of the total obstetrical panel when all the tests listed in the panel are performed on the same date of service. For example, if the total panel of tests and screenings is performed on the same date of service, providers must bill the total obstetrical panel using the bundled laboratory procedure code 80055.*

HIV Testing of Pregnant Women and Newborns

*Indiana Code IC 16-41-6-*5 requires that the physician or advanced practice registered nurse (APRN) who diagnoses a pregnancy or is primarily responsible for providing prenatal care during the pregnancy order human immunodeficiency virus (HIV) tests for pregnant women. If, at the time of delivery, there is no written evidence that such testing was performed during the pregnancy, *IC 16-41-6-6* requires the physician or APRN in attendance to order and submit a blood sample for HIV testing at that time.

In accordance with *IC 16-41-6-7*, pregnant women have the right to refuse this test.

IC 16-41-6-8 requires the physician, APRN, or the physician's or APRN's designee to:

- Inform the pregnant woman that the HIV test is required by law unless she refuses it and that she has the right to refuse the test.
- Explain the purpose, risks, and benefits of HIV testing.

As a routine component of prenatal care, the physician, APRN, or designee must provide information and counseling regarding HIV and HIV testing and offer and recommend the standard, licensed diagnostic test for HIV. Documentation that the pregnant woman was counseled and provided the information necessary to make an informed decision regarding whether or not to be tested must be maintained in the medical records. The provider must note the pregnant woman's oral or written consent or written refusal for the HIV test in the medical records.

The results of this test are confidential. If the test is positive for HIV, the provider must inform the pregnant woman of the test results and of the treatment or referral options available to her. In addition, the following information must be provided to pregnant women who test positive for HIV:

- A description of the methods of HIV transmission
- A discussion of risk reduction behavior modifications, including methods to reduce the risk of perinatal HIV transmission and HIV transmission through breast milk
- Referrals to other HIV prevention, healthcare, and psychosocial services

As described in *IC 16-41-6-4*, a physician overseeing the care of a newborn infant may order a confidential HIV test for the newborn within the first 48 hours after birth under the following circumstances:

- The mother of the newborn was not tested for HIV during the pregnancy or at delivery.
- The mother of the newborn has refused an HIV test for the newborn.*
- The physician believes that testing the newborn is medically necessary.

> **Note: If the parent objects, in writing, to testing the newborn for reasons pertaining to religious beliefs, the newborn is exempt from testing.*

If a physician orders an HIV test for a newborn under these circumstances, the physician must notify the mother of the test and provide HIV information and counseling, including information about the purpose of the test and the risks and benefits of testing. In addition, the results of the HIV test must be released to the newborn's mother. If the test results are positive, the individual who provides the test results must inform the mother of treatment or referral options available to the newborn.

Prenatal Immunizations

Refer to the following resources for guidelines for the recommended immunizations for pregnant women:

- The ACOG *Immunization for Women* web page at acog.org
- The AAP *Immunization Schedules* web page at aap.org
- The Centers for Disease Control and Prevention (CDC) *Immunizations Schedules* web page at cdc.gov

High-Risk Pregnancy

The National Institutes of Health (NIH) defines a high-risk pregnancy as a pregnancy that threatens the health or life of the mother or her fetus and often requires specialized care from specially trained providers. Some pregnancies become high risk as they progress, while some women are at increased risk for complications even before they get pregnant for a variety of reasons.

The IHCP does not determine conditions that may or may not complicate a pregnancy. Therefore, if a provider determines that an illness or injury could complicate a pregnancy or have an adverse effect on the pregnancy's outcome, the IHCP allows billing for covered services provided to treat the illness or injury.

Provider Restrictions for High-Risk Pregnancy Care

The IHCP reimburses high-risk-pregnancy care only when provided by one of the following:

- Physician
- Physician assistant
- Advanced practice registered nurse (APRN)

Providers that render pregnancy-related services to pregnant IHCP members must refer members identified as having high-risk pregnancies only to appropriate physicians, physician assistants, or APRNs. Services must be deemed medically necessary or preventive healthcare services, and provided within the scope of the applicable license and certification.

See the *Medical Practitioner Reimbursement* module for billing and reimbursement information related to services performed by a physician assistant or APRN.

Increased Reimbursement and Additional Prenatal Visits for High-Risk Pregnancy Care

Risk factors that may adversely affect the outcome of a pregnancy if not adequately treated may place the member in a high-risk pregnancy category that requires greater prenatal care management.

Therefore, the IHCP reimburses physicians, physician assistants, and APRNs practicing obstetrics an additional $10 per prenatal visit procedure code (59425 and 59426) when the provider indicates a high-risk pregnancy diagnosis code (from the O09 series) on the submitted claim. The provider must document the specific medical high-risk factors in the member's medical records and ensure that this information is easily identifiable in the medical record for audit purposes.

> *Note: To document high-risk pregnancies for **managed care** members, providers may retain a copy of the submitted NOP in the patient's record for retrospective review. If a normal pregnancy becomes high-risk at any time during the pregnancy, providers should use the NOP to document the change. See the Notification of Pregnancy section of this document for details.*

Additionally, members identified as high-risk may receive extra prenatal care visits beyond the maximum of 14 allowed for a normal pregnancy. Claims for these additional visits must indicate one of the high-risk pregnancy diagnosis codes (from the O09 series), the LMP, the appropriate CPT code (59426 for prenatal visits in excess of six), and the applicable trimester modifier.

For a complete list of high-risk pregnancy diagnosis codes, see the *ICD-10 Diagnosis Codes for High-Risk Pregnancy* table in *Obstetrical and Gynecological Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Injections for the Prevention of Preterm Delivery

The IHCP covers compounded 17-alpha hydroxyprogesterone (17P) and Makena injections when medically necessary for the prevention of preterm delivery. Both drugs may be billed through the pharmacy benefit process, as described in the *Pharmacy Services* module.

Coverage for Makena is also included under the IHCP medical benefit. Healthcare Common Procedure Coding System (HCPCS) code J1726 – *Injection, hydroxyprogesterone caproate, (Makena), 10 mg* may be billed on professional and institutional-outpatient claims. The product's National Drug Code (NDC) must be included. Separate reimbursement is available in the outpatient setting when J1726 is billed with revenue code 636.

Makena is considered medically necessary for pregnant women who have a history of spontaneous preterm delivery. Prior authorization is not required for the use of Makena.

Placental Alpha Microglobulin-1 (PAMG-1) Test

The IHCP reimburses for the placental alpha microglobulin-1 (PAMG-1) test when the test is considered medically necessary to confirm the diagnosis of premature rupture of membranes (PROM) or preterm premature rupture of membranes (PPROM). Prior authorization is not required for PAMG-1 testing; however, claims for this test are closely monitored for appropriateness of usage.

For reimbursement, providers should bill CPT code 84112 – *Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (e.g. placental alpha macroglobulin-1 [PAMG-1], placental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen* along with the appropriate trimester modifier (U1, U2, or U3). One PAMG-1 test equals one unit of service.

Prenatal Ultrasounds (Sonography/Echography)

The IHCP does not reimburse for routine ultrasounds or for ultrasounds performed for gender determination. A diagnosis of pregnancy alone does not substantiate the medical necessity of an ultrasound. Claims for prenatal ultrasounds performed when indicated for medical necessity must include the following:

- As the **primary** diagnosis – A **pregnancy** diagnosis code from the Z34 series (for normal pregnancy) or the O09 series (for high-risk pregnancy); for a complete list of diagnosis codes for normal and high-risk pregnancy, see *Obstetrical and Gynecological Services Codes,* accessible from the *Code Sets* page at in.gov/medicaid/providers
- As the **secondary** diagnosis – An appropriate **antenatal screening** diagnosis code that supports the medical necessity of an ultrasound; for qualifying conditions, see the *Indications for Medical Necessity of Ultrasound* section

Pregnancy-related ultrasounds billed without a secondary diagnosis to support medical necessity are subject to recoupment. Documentation in the patient's medical record must substantiate the medical need for the ultrasound.

Indications for Medical Necessity of Ultrasound

The IHCP reimburses for ultrasounds performed during pregnancy when warranted by one or more of the following conditions:

- Early diagnosis of ectopic or molar pregnancy
- Placental localization associated with abnormal bleeding
- Fetal postmaturity syndrome
- Suspected multiple births
- Suspected congenital anomaly
- Polyhydramnios or oligohydramnios
- Guide for amniocentesis
- Fetal age determination, if necessitated by the following:
  - Discrepancy in size versus fetal age
  - Lack of fetal growth or suspected fetal death
- Suspected uterine and pelvic abnormality
- Determination of fetal position
- Evaluation of cervix for risk of preterm loss or birth

The IHCP reimburses for ultrasounds for fetal age determination before therapeutic, nonelective abortions (in the case of fetal demise or for missed abortion [miscarriage]) when the age of the fetus cannot be determined by the patient's history and physical examination. The information may also be essential for the selection of the abortion method when the member is considering a procedure and the conditions meet the requirements of *IC 16-34-1-8* for an elective abortion.

First-Trimester Fetal Nuchal Translucency Ultrasound

The first-trimester fetal nuchal translucency ultrasound does not require prior authorization. However, the first-trimester fetal nuchal translucency ultrasound must be performed in conjunction with a maternal serum-free beta human chorionic gonadotropin (hCG) test and a pregnancy-associated plasma protein A (PAPP-A) test for the detection of chromosomal defects. The IHCP does not cover first-trimester fetal nuchal translucency testing when performed alone for the detection of chromosomal defects, as it is considered investigational.

For optimal test results, the first-trimester fetal nuchal translucency ultrasound should be performed between 11 and 13 weeks of pregnancy. First-trimester fetal nuchal translucency ultrasounds are subject to the requirements found in *405 IAC 5-27-6*.

As with all prenatal ultrasound claims, the pregnancy-related primary diagnosis code must be accompanied by a secondary diagnosis code to substantiate the medical necessity for a first-trimester fetal nuchal translucency ultrasound, and supporting documentation must be maintained in the patient's medical record.

Obstetrical Delivery and Postpartum Care

The IHCP provides reimbursement for obstetrical delivery and postpartum care when all coverage and billing requirements are met.

General Billing Guidelines for Obstetrical Delivery

The IHCP follows CPT guidelines for obstetrical delivery billing. The delivery service includes all the following:

- Admission to the hospital
- Admission history and physical examination
- Management of uncomplicated labor
- Delivery, including:
  - Vaginal delivery (with or without episiotomy, with or without forceps)
  - Cesarean delivery

Medical problems complicating labor and delivery management may require additional resources, and physicians should identify related services by using the codes in the *Evaluation and Management Services* module, in addition to codes for maternity care.

> *Note: The IHCP covers anesthesia services for a vaginal or cesarean delivery. For additional information, see the Anesthesia Services module.*

Professional claims (*CMS-1500* claim form or electronic equivalent) for obstetrical delivery (CPT codes 59409, 59514, 59612, and 59620) must include one of the following **modifiers**:

- UA – Nonmedically necessary delivery prior to 39 weeks of gestation
- UB – Medically necessary delivery prior to 39 weeks of gestation
- UC – Delivery at 39 weeks of gestation or later

Institutional claims (*UB-04* claim form or electronic equivalent) for obstetrical delivery services related to C-sections or inductions require one of the following **condition codes** (fields 18–24 of the *UB-04* claim form), in addition to the appropriate revenue codes and ICD procedure codes:

- 81 – C-sections or inductions performed at less than 39 weeks' gestation for medical necessity
- 82 – C-sections or inductions performed at less than 39 weeks' gestation electively
- 83 – C-sections or inductions performed at 39 weeks' gestation or greater

> *Note: Vaginal deliveries that occur due to spontaneous labor do not require condition codes on the institutional claim.*

See the *Early Deliveries* section for information about the appropriate uses of these gestational-stage modifiers and condition codes. For additional billing information specific to deliveries performed in freestanding birthing centers, see the *Birthing Centers* section.

Postpartum Care

The IHCP provides reimbursement for inpatient or outpatient postpartum visits within 60 days after delivery. The IHCP does not cover CPT codes for *combined* delivery and postpartum care (59410, 59515, 59614, or 59622) on fee-for-service (FFS) claims. Providers are required to bill delivery services and postpartum care services separately using the appropriate procedure codes.

Postpartum physician visits within 60 days after delivery are billed using CPT code 59430, which is for postpartum care only.

Early Deliveries

The IHCP does not cover early elective deliveries (EEDs), defined as deliveries performed prior to 39 weeks and 0 days gestation without medical indication. The IHCP does not reimburse for delivery CPT codes submitted with the UA modifier, signifying deliveries at less than 39 weeks of gestation that do not meet the IHCP's stated guidelines for approved medically necessary deliveries. Additionally, the IHCP does not reimburse institutional claims submitted with condition code 82, signifying an elective C-section or induction performed at less than 39 weeks of gestation. This EED policy applies to all IHCP programs.

Deliveries that meet one of the approved medical indications for a *medically necessary* delivery prior to 39 weeks (listed in Table 1) are covered. The medical indications listed in Table 1 are compiled from lists released by the Indiana Perinatal Quality Improvement Collaborative (IPQIC), ACOG, and the Joint Commission. This comprehensive list of medical indications is intended to ensure that all medically indicated deliveries prior to 39 weeks remain covered. The IHCP will continue to evaluate the list of approved medical indications to ensure that all medically necessary indications are covered.

For all early deliveries, documentation of the gestational age of the fetus and the medical indication for an early delivery must be completed and maintained in the member's file. Suggested forms for documentation are the *ACOG Patient Safety Checklists* on the ACOG website at acog.org or the *IPQIC Scheduling* form on the ISDH website at in.gov.

Table 1 – Approved Medical Indications for a Medically Necessary Delivery Prior to 39 Weeks and 0 Days

Maternal Indications	Fetal Indications	Obstetric Indications
• Antiphospholipid syndrome • Chronic hypertension • Cardiovascular diseases • Chronic pulmonary disease • Coagulopathy defect • Coagulopathy disorders • Congenital heart defect/ heart disease • Current cancer • Diabetes mellitus • Epilepsy/seizure disorder • Gastroenteric diseases/disorders • Hematological disorder • HIV; asymptomatic HIV infection status • Hypertension nonspecified • Liver disease • Maternal/fetal hemorrhage • Previous stillborn • Prior classical cesarean delivery • Prior myomectomy entering endometrial cavity • Prior uterine rupture • Renal disease	• Abo isoimmunization • Abnormal fetal heart rate • Chorioamnionitis • Congenital heart defect/heart disease • Fetal abnormality • Fetal chromosomal anomaly • Fetal central nervous system (CNS) anomaly • Fetal damage due to disease • Fetal damage due to drugs • Fetal damage due to radiation • Fetal damage due to virus • Fetal demise-singleton • Fetal distress • Fetal/maternal hemorrhage • Intrauterine growth restriction • Nonreassuring fetal antepartum testing • Rh isoimmunization	• Member presenting in labor • Abruptio placenta • Abruption • Alloimmunization • Antepartum hemorrhage/bleeding • Chronic hypertension with super imposed preeclampsia • Chorioamnionitis • Gestational diabetes • Gestational hypertension • Hypertensive disorder • Increta • Intrahepatic cholestasis of pregnancy • Maternal/fetal hemorrhage • Mild preeclampsia • Severe preeclampsia/HELLP/eclampsia • Multiple gestation • Multiple gestation with loss • Oligohydramnios • Percreta • Placenta accreta • Placenta previa • Placental previa hemorrhage • Polyhydramnios • Premature rupture of membranes • Prolonged rupture of membranes • Ruptured membranes • Unstable lie; multiple gestation with malpresentation • Vasa previa

Multiple Births

Multiple-birth deliveries are subject to multiple-surgery reimbursement. The reimbursement policy indicated in *405 IAC 5-28-1(g)* for pricing multiple surgical procedures states that 100% of the global fee is reimbursed for the most expensive procedure. The second most expensive procedure is reimbursed at 50% of the global fee, and remaining procedures are reimbursed at 25% of the global fee.

The IHCP reimburses for only one cesarean procedure, regardless of the number of babies delivered during the cesarean section. Therefore, only one detail line with one unit of service is billed for cesarean delivery procedure codes. Multiple births should be billed as follows:

- When billing for multiple births and all the births are by cesarean section, the births are billed as a single detail with a single unit of either procedure code 59514 – *Cesarean delivery only* or 59620 – *Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery*.
- When billing for multiple births and all the births are vaginal deliveries, the first birth is billed using procedure code 59409 – *Vaginal delivery only (with or without episiotomy and/or forceps*) or

59612 – *Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)*. The second birth and any subsequent births are billed using procedure codes 59409 or 59612 with modifier 51 – *Multiple procedures*.

- When billing for one vaginal birth and one or more births by cesarean section, the cesarean birth is billed with procedure code 59514 or 59620, and the vaginal birth is billed using procedure code 59409 or 59612 with modifier 51.
- When billing for two or more vaginal births and one or more births by cesarean, the cesarean births are billed on one detail line with one unit of service using procedure code 59514 or 59620. The vaginal births are billed as separate details using procedure code 59409 or 59612 with modifier 51.

The appropriate UA, UB, or UC modifier is also required for all CPT delivery codes, as described in the *General Billing Guidelines for Obstetrical Delivery* section. For modifier requirements and reimbursement information related to assistant surgeon services during delivery, see the *Surgical Services* module.

Reimbursement for Long-Acting Reversible Contraception Implanted During Delivery Stays

The IHCP allows separate reimbursement for certain long-acting reversible contraception (LARC) devices implanted during an inpatient hospital or birthing center stay for a delivery. For applicable HCPCS codes, see *Obstetrical and Gynecological Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

To receive separate reimbursement for LARC devices implanted during inpatient hospital or birthing center stays for delivery, the appropriate HCPCS code should be billed on a professional claim (*CMS-1500* claim form or electronic equivalent). Separate reimbursement applies to the LARC devices only. Reimbursement for all other related services, procedures, supplies, and devices continue to be included in the inpatient hospital diagnosis-related group (DRG) or the birthing center all-inclusive reimbursement amount.

For more information about LARC devices, see the *Family Planning Services* module.

Birthing Centers

A freestanding birthing center, as defined by *IC 16-18-2-36.5* and *410 IAC 27-1-3*, is a licensed, freestanding entity that has the sole purpose of delivering a normal or uncomplicated (low-risk) pregnancy. This term does not include a hospital under *IC 16-21-2*, an ambulatory surgical center, or the residence of the woman giving birth.

Birthing centers are licensed to provide care during pregnancy, birth, and the immediate postpartum period to the low-risk expectant mother and her newborn. Each center shall admit and retain only low-risk expectant mothers anticipating a normal, full-term, spontaneous vaginal birth.

Services provided in a birthing center shall be limited in the following manner:

- Members receiving the services must be considered low-risk, or having a normal, uncomplicated pregnancy as defined in *410 IAC 27-1-15.5*.
- Delivery shall be performed by one of the following professionals:
  - Certified nurse midwife
  - Physician
- Surgical services are limited to episiotomy and episiotomy repair, and shall not include operative obstetrics or cesarean sections.
- Labor shall not be inhibited, stimulated, or augmented with chemical agents during the first or second stage of labor.
- Systemic analgesia may be administered and local anesthesia for pudendal block and episiotomy repair may be performed.

- General and conductive anesthesia shall not be administered at birthing centers.
- Members shall not routinely remain in the facility in excess of 24 hours.

Facility Billing and Reimbursement

The IHCP created provider type 08 – *Clinic* and provider specialty code 088 – *Birthing center* to identify birthing centers. Birthing centers must be licensed by the Indiana State Department of Health (ISDH) before enrolling in the IHCP. Birthing centers are assigned to the limited risk category and are not required to pay an application fee during enrollment or revalidation (see the *IHCP Provider Enrollment Risk Category and Application Fee Matrix* at in.gov/medicaid/providers). Providers should refer to the *IHCP Provider Type and Specialty Matrix* at in.gov/medicaid/providers for other enrollment criteria.

Facility charges are billed on an institutional claim (*UB-04* claim form or electronic equivalent). Birthing center claims must report billing provider taxonomy code 261QB0400X (birthing) on the claim.

Birthing centers are paid at an all-inclusive rate. The services are billed using revenue code 724 – *Birthing center*. Only vaginal deliveries should be billed with this revenue code. Reimbursement rates are based on the revenue code 724 when the member delivers. When labor occurs but does not result in delivery, providers should bill revenue code 724 along with HCPCS code S4005 – *Interim labor facility global (labor occurring but not resulting in delivery)*.

Professional Billing and Reimbursement

Professional services rendered at birthing centers are billed on a professional claim (*CMS-1500* claim form or electronic equivalent). Services rendered by the following providers are payable when performed at birthing centers:

- *Certified nurse midwife* (Provider type 09, specialty 095)
- *Physician* (Provider type 31, all specialties)

Professional charges are reimbursed directly to the practitioner at the applicable reimbursement rate. Other staff services, such as services provided by registered nurses (RNs) and licensed nurse practitioners (LPNs), are included in the delivery rate and not separately reimbursed.

Birthing center professional services are to be billed with place-of-service code 25 – *Birthing center*.

Abortion and Related Services

The IHCP uses the word *abortion* to describe the early termination of pregnancy. The IHCP does not consider termination of an ectopic pregnancy to be an abortion.

There are two types of abortion:

- *Spontaneous abortion* (or *missed abortion*) occurs for no apparent reason during early pregnancy and requires treatment to ensure the health of the mother. The IHCP reimburses for therapeutic treatment of spontaneous or missed abortion, and services relevant to this treatment, according to the IHCP-allowable amount. Providers should follow the coding guidelines included in this section.
- *Elective abortion* is an abortion that a doctor performs because the mother has chosen to terminate the pregnancy. *IC 16-34-1-2* prohibits the State from making payment from any fund under its control for an elective abortion, unless the elective abortion is necessary to preserve the life of the pregnant woman or unless federal law requires the State to cover it, such as in the case of rape or incest. Elective abortions performed for any other reason are noncovered services according to *405 IAC 5-28-7*. Providers must adhere to the procedures described in the following section to obtain payment for an elective abortion.

Documentation Requirements

For spontaneous abortions, the IHCP requires no documentation from providers billing with the appropriate treatment code and following the guidelines described in this document.

For elective abortions, the physician must specify in writing the physical condition of the patient leading to the professional judgment that the abortion was one of the following:

- Necessary to preserve the life of the pregnant woman
- Due to rape or incest

The documentation must contain the name and address of the member, dates of service, physician's name, and physician's signature. Providers must attach this documentation to the paper claim form, upload it to the Portal claim, or send it separately as an attachment to the electronic claim transaction (as described in the *Mailing Paper Attachments for Electronic Claims* section of the *Claim Submission and Processing* module). The IHCP must receive correct documentation with claims before it will make payment for the elective abortion or any directly related service. The primary service provider should forward copies of the physician certification to the related service provider to bill for these services.

If providers submit a claim with a diagnosis code or procedure code indicating that a possible elective abortion was performed, the IHCP requires documentation for claim payment consideration. The IHCP suspends these claims for review of medical documentation. For lists of diagnosis codes and procedure codes that suspend for appropriate documentation supporting medical necessity, see the following tables in *Obstetrical and Gynecological Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers:

- *ICD-10 Abortion Diagnosis Codes That Suspend for Appropriate Documentation Supporting Medical Necessity*
- *CPT and HCPCS Abortion Procedure Codes That Suspend for Appropriate Documentation Supporting Medical Necessity*
- *ICD-10 Abortion Procedure Codes That Suspend for Appropriate Documentation Supporting Medical Necessity*

Medical Abortion by Oral Ingestion of Medication

The IHCP reimburses for mifepristone and misoprostol for use in medical abortion procedures based on the same coverage criteria applicable to surgical abortions.

The IHCP reimburses only the Food and Drug Administration (FDA)-approved regimen for medically induced abortions using orally administered mifepristone and misoprostol. The IHCP does not reimburse what is commonly known as the *evidence-based* regimen for medical abortion with mifepristone and misoprostol, which includes at-home or vaginal administration of misoprostol.

The FDA-approved regimen for these medications is as follows:

- Recommended gestational age – 49 days from last menstrual period
- Mifepristone dose – 600 mg orally administered on Day 1 office visit
- Misoprostol dose – 400 mcg orally administered on Day 3 office visit
- Misoprostol timing – 48 hours after receiving mifepristone

Medical abortion by oral ingestion of mifepristone and misoprostol requires three separate office visits to complete the procedure. Confirmation of pregnancy status must occur before the Day 1 office visit. The Day 1 office visit must occur after the 18-hour counseling and waiting period required by *IC 16-34-2-1.1(a)(1)*.

The following list shows the billing guidelines for these office visits and the medications provided during the office visits. Providers must bill all claims for medical abortion by oral ingestion of mifepristone and misoprostol on the professional claim (*CMS-1500* claim form or electronic equivalent).

- Day 1:
  - Member reviews and signs the *Patient Agreement*.
  - Provider orally administers three 200 mg tablets of mifepristone.
  - Provider bills HCPCS code S0190 – *Mifepristone, oral, 200 mg,* three units.
  - Provider bills the appropriate E/M code for the office visit.
- Day 3:
  - Provider checks pregnancy status with clinical examination or ultrasound exam.
  - If an ultrasound is performed, provider bills the appropriate code for the service provided.
  - Provider orally administers two 200 mcg tablets of misoprostol.
  - Provider bills HCPCS code S0191 – *Misoprostol, oral, 200 mcg*, two units.
  - Provider bills appropriate E/M code for the office visit.
- Day 14:
  - Provider verifies pregnancy termination with clinical examination or ultrasound exam.
  - If an ultrasound is performed, the provider bills the appropriate code for the service provided.
  - Provider bills appropriate E/M code for the office visit.

The IHCP suspends claims for Day 1 and Day 3 office visits pending submission of required documentation. To be reimbursed for services, the IHCP requires providers to submit all necessary documentation with claims for these office visits, as described in the *Documentation Requirements* section.

In addition, medical abortion by oral ingestion of mifepristone and misoprostol requires submission of the signed *Prescriber's Agreement* and *Patient Agreement*. These agreements are available from Danco Laboratories, and Danco requires their use. Providers must attach documentation to the paper claim form, upload it to the Portal claim, or send it separately as an attachment to the electronic claim transaction (as described in the *Mailing Paper Attachments for Electronic Claims* section of the *Claim Submission and Processing* module). If providers fail to submit this documentation, the IHCP must deny the claims.